IMPROVING HEALTH INSURANCE COVERAGE FOR LATINO CHILDREN: A REVIEW OF BARRIERS, CHALLENGES AND STATE STRATEGIES

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Objectives: To summarize key findings on disparities in health insurance coverage for latino children, to present selected socioeconomic and healthcare access indicators for the nine states with latino populations over 500,000, and to recommend state strategies to increase public health insurance coverage for latino children.

Methods: Literature review performed on latino children and health insurance coverage, key informant interviews with frontline service providers, review of outreach sections of eight state 1115 waiver requests approved by the Secretary of the U.S. Department of Health and Human Services, and national and state data compiled on sociodemographic and healthcare access indicators for nine states with the largest latino populations.

Results: Eligibility and enrollment into Medicaid and State Children's Health Insurance Program (SCHIP) are hindered by financial, nonfinancial, and social policy barriers. Disparities in insurance and access indicators show that lack of parental employment-linked benefits, procedural barriers to enrollment, and lack of clarification on eligibility for children of noncitizen parents are associated with low levels of insurance coverage among latino children.

Conclusion: To state strategies consistent with the overarching goal of Healthy People 2010 to eliminate health disparities can increase health insurance coverage for children of low-wage latino workers. (*J Natl Med Assoc.* 2004;96:508–523.)

Key words: latino ◆ Hispanics ◆ children ◆ Medicaid ◆ SCHIP ◆ healthcare ◆ access ◆ state

INTRODUCTION

Lack of health insurance coverage is a long-standing policy issue for the latino population and for latino children in particular.[1-7] During the past two decades, the percent of uninsured Hispanics has doubled to 37.1%.[8-10] Hispanics in California, Florida, New York, and Texas account for 69% of all Hispanics and represent 73% of all uninsured Hispanics. Four out of 10 Hispanics living in California and Texas, and one out of three Hispanics in Florida and New York are uninsured.[10,11]

In 2000, 35.7% of latinos were less than 18 years of age.[12] Parental inability to pay for healthcare is the most important barrier to accessing healthcare for latino children, with the uninsured being more likely to delay seeking care and not have a usual source of care. Hispanic children are less likely than non-Hispanic white (NHW) and African-American children to have health insurance coverage—a usual source of

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care—to visit a physician, to receive routine checkups, to use preventive healthcare services; and are more likely to report being in fair or poor health.[9-11,13-23]

Among poor children, Hispanic children are more likely to be uninsured for the entire year (31.1%) compared to African-American (15.3%) and NHW (18.3%) poor children. Although 56% of poor Hispanic children are enrolled in Medicaid, a disproportionate percentage of uninsured Medicaid-eligible children are latino (35%) and African-American (33%), compared to NHW (18%) children.[23-26] Latino children are the most economically disadvantaged regardless of family structure[12] but have not benefited equally from expanded access to public health insurance through the State Children's Health Insurance Program (SCHIP) and enhanced outreach efforts to enroll children in Medicaid.[25-30]

The purposes of this paper are to summarize key findings on disparities in health insurance coverage for latino children, to present selected socioeconomic and healthcare access indicators for nine states of largest latino population, and to recommend state strategies to increase public health insurance coverage for latino children. Data presented here can serve as a baseline to assess the effectiveness of state strategies to improve access to healthcare for latino children.

METHODS

Four major methods were used: a computerized literature search on latino children and health insurance coverage and access barriers for the years 1965–2002; key informant interviews with health providers of latinos in the Washington, DC metropolitan area; a review of outreach sections of eight state 1115 waiver requests*; and a compilation of state sociodemographic and healthcare access indicator data. The databases searched included Medline, Sociofile, Psyclit, Social Science Citation Index, Science Citation Index, and CINAHL. The following keywords were used: latino, Puerto Rican, Mexican American, Cuban, Hispanic, Minority, Health, Child, Access, and Children. Policy and research reports were obtained from major national organizations and reviewed to assess key policy consensus points and their consistency with research findings. Unpublished studies were also requested from colleagues and a network of associates whose research relates to latino child health.

The second approach involved interviews with two physicians and a health educator who were front-line providers for uninsured and underinsured children within the Washington, DC metropolitan area. Barriers to accessing healthcare and strategies to address these barriers were first identified in the literature and ranked in order of mention. Information from the key informant interviews was used to clarify and reorder the common barriers to access to healthcare services, and successful outreach and enrollment strategies for low-income Medicaid- and SCHIP-eligible children.

The third approach included a review of the outreach sections of eight state 1115 waiver requests approved by the Secretary of the Department of Health and Human Services: California, Colorado, Connecticut, Florida, Illinois, New York, Ohio, and South Carolina. Healthcare access barriers and strategies were first identified from the literature and key informant interviews to develop a review guideline. Outreach sections of state 1115 waiver requests were then reviewed using this guideline for mention of healthcare access barriers and strategies. Although outreach can be defined as efforts to ensure both enrollment in a program and access to covered services, states primarily focused on strategies to increase enrollment into the program. A summary of the barriers and proposed strategies found during the literature review, key informant interviews, and review of the outreach sections of the approved state 1115 waiver requests is shown in Table 3.

Finally, sociodemographic and state healthcare access indicators were obtained from the Census, Current Population Survey, national health surveys, and state vital statistics for Hispanic children and adults in nine states that represent over three-quarters of the Hispanic population: Arizona, California, Colorado, Florida, Illinois, New Jersey, New Mexico, New York, and Texas. However, these data require caution in interpretation for three reasons: survey instruments may not have adequately addressed language and literacy barriers, the use of observer identification in vital statistics may not have accurately identified Hispanic ethnicity,[31] and estimates of the uninsured vary by data source, year, and criteria used. Generalizations are limited since data selected from a subset of the latino population may not be representative of latinos by subgroup and geographic location. By analyzing the results of each study as if latinos represent a homogenous population with common characteristics and behaviors, important access patterns by subgroup may be overlooked.[31-34]

RESULTS

Sociodemographics of Latino Children in the United States Overall and the Nine Focus States

Table 1 shows sociodemographic indicators for the total Hispanic population in the United States (Column 1), for Hispanic populations in each of the nine states with the largest population of Hispanics, and for the total NHW population. In New Mexico, latinos constitute 42.1% of the total state population and close to one-third of the state population in both Texas and California. The latino population tends to be young, with a median age of 25.9 years—with the exception of Florida, reflecting an older Cuban cohort with a median age of 32.2 years. High-school graduation rates vary from a low of 45% in Texas, California, and Illinois to almost 60% in New Mexico.[24] Overall, 10.6% of latinos have at least a bachelor's degree. Latinos in Florida had the highest college completion rates, while latinos in Arizona, California, and Texas had the lowest college completion rates.[35] A persistent trend among latinos is that although they have high labor force participation rates (ranging from 90% in California to 63% in New Mexico), low levels of education are highly associated with low-median household income.[36] The percentage of latino children who live below the official poverty level vary from 41.9% in New York to 25% in Florida and Illinois. Latino families with children under 18 are almost four times as likely to live in poverty (22.7%) as NHW families (6.1%).[35,37]

Disparities in Access to Healthcare for Latino Children in the United States

Table 2 displays 22 selected healthcare access indicators for Hispanics in nine states to assess potential eligibility and barriers to healthcare access. Indi-

Table 1. Selected Hispanic Sociodemographic and Health Indicators in Nine States with the Largest Latino Population

Indicator	Total Hispanic	AZ	CA	CO	FL	IL	NJ	NM	NY	TX	Non-Hispanic Whites
Hispanics by total state population (%)	12.5	25.3	32.4	17.1	16.8	12.3	13.3	42.1	15.1	32.0	
Mexican American	58.5	82.2	77.1	61.3	13.6	74.8	9.2	43.1	9.1	76.0	
Puerto Rican	9.6	1.4	1.3	1.8	18.0	10.3	32.8	0.6	36.6	1.0	
Cuban	3.5	0.4	0.7	0.5	31.1	1.2	6.9	0.3	2.2	0.4	
Central American	4.8	1.0	5.3	1.3	7.6	2.6	7.2	0.3	6.3	2.2	
South American	3.8	0.6	1.5	1.0	11.2	2.5	15.8	0.3	11.1	0.8	
Other Hispanic	17.6	14.3	14.2	34.1	16.0	8.4	18.8	55.4	18.8	19.5	
Median age (years)	25.9	24	24.4	25.8	32.2	24.1	27.9	28.6	28	24.5	35.5
High-school graduates[1] (%)	57.0	51.7	45.0	58.3	57.2	45.0	53.9	59.6	50.4	44.6	83.0
Bachelor's or higher[1] (%)	10.6	6.9	7.0	9.0	14.2	10.5	10.8	8.7	9.3	7.3	27.6
Labor force participation[1] (%)	67.9	89.0	90.0	68.0	64.9	72.2	71.7	63	87.7	66.7	67.3
Median family income[1]	$22,033	$20,000	$23,032	$28,000	$23,208	$30,120	$28,000	$21,457	$18,000	$22,102	$38,885
Below poverty level[1] (%)	23.1	28.3	21.6	25.5	19.5	20.0	19.1	27.8	30.5	33.0	7.7
Children in poverty[1] (%)	30.3	35.0	27.2	33.0	25.0	25.0	28.0	35.0	41.9	40.2	9.4

1 Source: U.S. Census Bureau, Census 2000, Summary File 1 and unpublished data. Internet Release date: October 22, 2001.

Table 2. State Profiles of Healthcare Access Indicators for Hispanics in Nine States^

US	AZ	CA	CO	FL	IL	NJ	NM	NY	TX
Percent Hispanic^^ (2000)									
12.5	25.3	32.4	17.1	16.8	12.3	13.3	42.1	15.1	32
Percent nonelderly Hispanic without health insurance (2001)									
35	33	34	36	36	31	31	26	31	41
Percent nonelderly Hispanic with employer coverage (2001)									
44	45	43	53	46	56	53	49	37	42
Percent 19–35-month-old Hispanic children immunized (2000)									
69	71	72	NSD	74	63	NSD	68	65	62
*Percent Hispanic women with no prenatal care in first trimester (2000)^^^*									
25.6	34.6	19.3	34.6	19	27.4	31.4	34.2	27.1	28.8
Rate of nonfederal physicians per 100,000 of civilian population (2001)									
268	217	255	251	253	277	331	223	395	214
Percent Hispanic of nonfederal physicians (2001)									
2.9	3.6	3.0	1.7	11.3	2.7	2.8	7.3	2.7	7.2
Status of SCHIP Section 1115 demonstration projects (2002)									
NA	Approved	Approved	Approved	No	No	Approved	Approved	No	No
SCHIP type (2002)									
NA	Separate CHIP	Combo	Separate CHIP	Combo	Combo	Combo	Medicaid Expansion	Combo	Combo
Eligibility level for children in separate SCHIP program (2002)									
NA	200%	250%	185%	200%	185%	350%	NA	250%	200%
States with joint application under medicaid for children and separate SCHIP program (2002)									
33 Yes	Y	Y	Y	Y	Y	Y	NA	Y	Y
States that have eliminated face-to-face Interview under Medicaid for children (2002)									
47 Yes	Y	Y	Y	Y	Y	Y	N	N	Y
States that have eliminated face-to-face interview under separate SCHIP program (2002)									
34 Yes	Y	Y	Y	Y	Y	Y	NA	Y	Y
States that have eliminated asset test under Medicaid for children (2002)									
45 Yes	Y	Y	N	Y	Y	Y	Y	Y	N
States that have eliminated asset test under separate SCHIP program (2002)									
34 Yes	Y	Y	Y	Y	Y	Y	NA	Y	Y
States with presumptive eligibility under Medicaid for children (2002)									
9 Yes	N	N	N	Y	N	Y	Y	Y	N
States with presumptive eligibility under Separate SCHIP program (2002)									
5 Yes	N	N	N	N	N	Y	NA	Y	N
States with 12-month continuous eligibility under Medicaid (2002)									
18 Yes	N	Y	N	Y	Y	N	Y	Y	N
States with 12-month continuous eligibility under SCHIP (2002)									
23 Yes	Y	Y	Y	N	Y	N	NA	N	Y
States that allow self-declaration of income under Medicaid for children (2002)									
13 Yes	N	N	N	Y	N	N	N	N	N
States that Allow Self-declaration of income under Separate SCHIP program (2002)									
11 Yes	Y	N	N	Y	N	N	NA	N	N
SCHIP federal matching rate FY2003 (2002)									
NA	77%	65%	65%	71%	65%	65%	82%	65%	72%

^ Adapted from Kaiser Family Foundation State Health Facts Online, Henry J. Kaiser Family Foundation; ^^www.census.gov, Table DP-1; ^^^National Vital Statistics Report, Vol. 50, No. 5, February 12, 2002.

cators include, for example, the percent of uninsured nonelderly Hispanics, per-capita healthcare expenditures, rate of nonfederal physicians per 100,000 population, percent of latino nonfederal physicians, and Medicaid and SCHIP access indicators.

Insurance Disparities. About one-third of nonelderly latinos residing in the nine states are uninsured—ranging from 26% in New Mexico to 41% in Texas. Although not shown here, California, Florida, New York, and Texas account for 52% of SCHIP enrollment nationwide.[38]

In addition, enrollment increases in these four states account for 62% of nationwide SCHIP enrollment growth between 2000 and 2001. Nationally, latino adolescents (31.6%) are twice as likely as African-American, and three times more likely than NHW adolescents to be uninsured.[13] Thus, access to healthcare of latino children and adolescents is compromised by the limited economic viability of their parents to purchase insurance that impedes use of preventive health services for both U.S.-born and immigrant latino children and adolescents.[23,39,40]

Access Indicator Disparities. In examining select child well-being indicators, such as immunization rates for 19–35-month-old children and receipt of prenatal care in first trimester, we observe similar patterns of use that are associated with lack of health insurance. Sixty-nine percent of 19–35-month-old latino children were immunized in 2000—much lower than the year-2000 goal of 90% for all children.[41] In Illinois, New York, and Texas, immunization rates for all children are considerably below the reported national average. Seven out of the nine states with the largest latino population rank in the bottom half of states for vaccine coverage for 19–35-month-olds. The percent of latinas who did not receive prenatal care during the first trimester ranges from a high of 34.2–34.6% in New Mexico and Colorado to a low of 19% in Florida.

Indicators of accessibility for eligible children were explored. Arizona, New Mexico, and Texas had the lowest rate of nonfederal physicians per 100,000 civilian populations, with New York and New Jersey having the highest. The percent of nonfederal physicians who are latino ranged from a high of 11.3% in Florida to a low of 1.7% in Colorado.

Latino children are more likely to be uninsured and, thus, are more likely to experience negative health outcomes. Uninsured latino children are 1.7 times less likely to receive medical treatment for sore throats, 1.2 times less likely to receive medical treatment for recurrent earaches, and 1.3 times less likely to receive medical treatment for asthma.[13] The older the latino child, the more likely they are to not have visited a physician in the last year. Although only about 11.7% of latino children under age four years of age have not visited a physician in the last year, 37% of adolescents 15–19 reported no physician visit during this period.[40-42]

Health Status Disparities. Latino children have lower ratings of overall health status with only about 60% reported to have excellent health or very good health, compared to 90% of NHW children. Latino children are less physically active and have higher rates of sedentary activity—trends that are associated with overweight, obesity and recent increases in the prevalence of type-2 diabetes among Mexican-American children.[43-45] Children in urban and rural areas of California have poorer health status due to health risks and less access to medical care compared to children living in suburban areas.[29]

Barriers to Obtaining Coverage for Latino Children and Families

Financial Barriers to Enrolling in Health Coverage Programs. A low level of employer-sponsored coverage is the principal reason why so many latino families are uninsured. Only 43% of latinos get coverage through their own employer or that of a family member, well below the national rate of 64%.[10,11,46,47] Latinos have high rates of labor force participation (78.4%) in minimum-wage jobs without health-linked benefits that often disqualify them from Medicaid eligibility,[48] and about 27% do not earn enough to pay for private health insurance.[38,49] Fifty-six percent of uninsured Hispanic families live with a full-time, full-year worker—comparable to NHWs (55%) and higher than African Americans (44%).[11] The lack of employer-sponsored coverage leaves few affordable alternatives, especially for those individuals with low incomes.[48]

Medicaid insures only 15% of all latinos under age 65[11] but 56% of poor latino children.[25] The ability of low-income and low-wage latino workers to obtain employment-based coverage may have deteriorated over the last decade,[49-53] since latinos are twice as likely as the overall population to belong to a family where the primary wage earner makes less than $7 an hour (26% of Hispanics, compared with 13% overall)[11] and to live in cities that have lower rates of employer-based coverage. Metropolitan Statistical Areas with the lowest rate of job-

based health insurance are located in Arizona, California, Florida, New Jersey, New Mexico, New York, and Texas.[54] Latinos are more likely to be employed in industries and occupations that do not offer health benefits.[55] Within these industries, they are less likely than non-Hispanics to be offered health coverage by their firm. Even when low-wage workers are offered health insurance, many have difficulty paying their share of the premiums for coverage that is often of inferior quality.[56-58] Thus, financial barriers, such as paying for medical bills, and cost of medications, deter latinos from accessing routine care for their children and managing existing chronic childhood illnesses.[59-61]

Nonfinancial Barriers to Enrolling in Health Coverage Programs. Multiple nonfinancial factors have been consistently identified over the last three decades as barriers to accessing healthcare services among eligible latino children.[2,3,45,62,63] Eligibility and enrollment barriers for low-income latino children include: parents being unaware of child's eligibility; complex application process; fear and mistrust of government or providers; and literacy, language, and logistical barriers.[43,45] Limited English-language proficiency (LEP) coupled with low education and literacy levels substantially reduces access to and quality of services received.[37-43] Almost one-quarter of Hispanics in the United States (4,548,677 or 23.8%) are linguistically isolated—that is no one 14 years old or over speaks only English, and no one who speaks a language other than English speaks English "very well."[12,30]

Structural factors, place of residence, and distribution of healthcare resources are all factors that are equally powerful determinants in accessing healthcare services. Structural factors in public benefit systems, such as continuously changing policies and criteria for eligibility, complexity of application process, and lack of outreach to potential eligible beneficiaries, impede access. These factors, combined with excessive waiting periods for services; transportation problems, such as lack of a car, difficulty using public transportation; and limited cultural and language competence on the part of medical staff who serve latino families prevent eligible latino children from accessing appropriate and needed public financed health services.[7,42-44]

Social Policy Barriers to Enrolling in Health Coverage Programs. The vast majority of latino uninsured children are eligible for public health insurance. However, new immigration and welfare reform policies in the last five years have inhibited eligible children from obtaining public insurance for multiple reasons. Welfare reform has affected health insurance coverage of children in 33 states, primarily through reductions in their Medicaid caseloads.[64,65] Although 39.1% of all U.S. latinos were foreign born in 2000,[12] 87% of latino children are U.S. citizens. The majority of all immigrant latino children reside in six states: California, New York, Florida, Texas, New Jersey and Illinois.[66,67] Among Mexican Americans, the largest latino subgroup, about 85% are legal residents or U.S. citizens yet they are the most likely to be uninsured and to have children under the age of 18 years of age.[12] Regardless of legal status, latino children are the least likely to have health insurance coverage. Eighteen percent of latino children born in the United States to U.S.-citizen parents and 21% born in the United States to noncitizen parents do not have health insurance, compared to 10% of NHW children.

The proportion of low-income, noncitizen children who participated in Medicaid or SCHIP fell during 1996 to 2001 from 28.6% to 24.8%.[66] Citizen children in immigrant families also lost publicly funded coverage, and more of them became uninsured immediately following passage of the federal welfare law of 1996.[67] Fix and Zimmerman suggest that children from "mixed-status families" (where the child is a citizen and the parent is a noncitizen) may not receive the same opportunities as other citizens due to their parent's legal status.[68] Over 25% of children in California[69] and 40% of eligible latino children are of mixed status.[68] State efforts to clarify eligibility for public health insurance programs have played an important role in the 7.7% increase in Medicaid or SCHIP enrollment of low-income children from mixed-status families during 1996 to 2001.[70-74]

Welfare and immigration reforms have restricted and diminished overall latino's use of public benefits, especially among immigrant groups.**[,10,75,76] In response to this legislation, there has been a decrease in latino children's access to and use of public entitlements such as SCHIP, Medicaid, immunization, and treatment for communicable diseases, which not only increases their physical vulnerability but also jeopardizes the public health of the entire nation.[74] According to a White House press release (May 25, 1999),[77] health insurance applications by immigrants in Los Angeles County decreased 21% between 1996 and 1998, indicating the reluctance of immigrants to use publicly funded benefits following changes in national immigration and welfare policies. Immigra-

tion status and length of residency are significantly linked to decreased access to healthcare for latino children. Evaluation of SCHIP has noted that outreach efforts need to address public charge-related fears among immigrants.[73-75]

Assessment of State Implementation of Health Coverage Programs for Eligible Children. Information on the steadily rising enrollment in SCHIP and corresponding decline in the number of uninsured children, from 9.9 million (13.9%) in 1997 to 7.8 million (10.8%) in 2001[78] suggests that SCHIP has succeeded in expanding health insurance cov-

Table 3. Strategies to Address Barriers to

Key Finding	Barrier
Medicaid eligibility and enrollment into publicly financed healthcare systems are hindered by institutional and other nonfinancial barriers.	Lack of awareness
	Complexity of application process
Lack of health insurance among latino children and adolescents is associated with lack of employment linked benefits.	Financial (e.g., cost too much, could not afford to leave work)
Immigrant status and length of residence as criteria for Medicaid eligibility have been clarified through federal public guidance.	Fear and mistrust of the government or providers (e.g., fear for undocumented family members, prior mistreatment by government or police, prior mistreatment by health staff)
	Logistical (e.g., lack of transportation to get to office; lack of child care; time to apply, ask questions, receive application; location of facilities; convenience of office hours)
	Linguistic and cultural (e.g., limited English proficiency, literacy level, lack of respect of providers or health officials, provider has lack of understanding of patient's medical beliefs and practices, patient uncomfortable with western medical practices, remove stigma of "welfare")

erage among children. Few states have compared the number or rate of uninsured children before and after SCHIP.[65] Some states have reported that Medicaid enrollment attributable to SCHIP has exceeded the level of SCHIP enrollment, which suggests that SCHIP may have a more dramatic effect on reducing the number of uninsured, low-income children than reflected by SCHIP enrollment patterns. Although the increase in public health insurance coverage has been accompanied by a decrease in private health insurance coverage, states do not see crowd-out, or replacement of private coverage

Public Health Insurance and Services
Strategies
• Distribute information about child health insurance programs through nontraditional sites (such as established providers, Medicaid offices, child care centers, community clinics, local hospitals, Head Start programs, refugee resettlement programs, TANF offices, special education offices, Social Security offices, Food Stamp offices, WIC, school lunch programs, local community centers, grocery stores) and to children at school to give to parents. • Outstation eligibility workers to locations other than state welfare offices or federal offices for on-site eligibility to services. • Train community health educators to reach the entire community. • Establish toll-free number to obtain application and answer questions with multilingual prompts.
• Streamline application process using one form for Medicaid and SCHIP. • Make application and bilingual staff available in appropriate language for assistance. Translator services should be available during patient's appointment. • Allow application to be submitted through the mail. • Give clinics on-site authority for presumptive eligibility. • Establish toll-free number to obtain application and answer questions with multilingual prompts.
• Eliminate or reduce copayment and deductible. • Assure 12-month continuous eligibility (regardless of changes in family income during that period). • Subsidize employment-linked health benefits. • Provide family-eligible Medicaid for low-wage workers.
• Prohibit excluding health and social services to eligible immigrants. • Require and maintain confidentiality between provider and patient and the Medicaid administration office regarding residency status of patient and family members. • Train and use community health educators to reach the entire community and to build trust. • Work with local media to inform them of confidentiality and public charge. • Determine eligibility at the clinic site.
• Coordinate with public transportation. • Provide childcare services at the facilities during visit. • Assure 12-month continuous eligibility (regardless of changes in family income during that period).
• Disseminate and enforce HHS guidelines for providing services to Limited English Proficiency (LEP) populations. • Provide written signs and fliers in areas frequented by target populations and use billboards in public transportation areas and radio stations to publicize programs. • Provide bilingual staff and interpreters at all key points of contact. • Provide translator services during the patient's appointment. • Support staff development and training in cultural competency to include appropriate involvement of family members and appropriate service delivery. • Train community health educators to reach entire community and to build trust. Cultural competency training is not just limited to physicians. • Establish toll-free number to obtain application and answer questions with multilingual prompts.

through SCHIP, to be a problem.

Retention of eligible children has emerged as a concern and priority for many states. Separate state programs have comprehensive benefit packages that appear to be meeting the needs of enrolled children. Access is generally described as "good;" however, access to dental care, specialist care, and access in rural areas where provider shortages exist are more problematic. States with separate programs have made extensive use of cost-sharing under SCHIP; however, cost-sharing does not appear to be a barrier to enrollment or service use.[79-84]

In 1999, Congress mandated a three-year study of SCHIP since little systematic analysis of the implications of states' program choices on enrollment had been conducted. The first year of the three-year study showed that families are generally satisfied with SCHIP and Medicaid and that awareness of SCHIP continues to grow but is still not as high as awareness of Medicaid.[85] Outreach strategies for separate state programs typically consist of statewide media campaigns to increase public awareness and community-based efforts to reach hard-to-reach families. Medicaid expansion states rely primarily on community-based outreach strategies. Community-based outreach workers play an important role by helping families complete SCHIP applications. Many of SCHIP's simple application enrollment processes have been adopted in Medicaid, but barriers to Medicaid enrollment remain. Medicaid is still associated with welfare in many parents' minds, and this perception is a barrier to enrollment into Medicaid. Although low-income families expressed a widespread interest in enrolling their children in SCHIP or Medicaid, the interim report concluded that knowledge and enrollment barriers for SCHIP and Medicaid still exist for low-income families.

State-specific evaluation studies shed light on the effectiveness of state strategies to enroll children in SCHIP and Medicaid. Personalized outreach activities, such as hotlines and home visits, have been found to be more effective than mass-media approaches.[65] According to state ratings, the most effective outreach settings were provider locations, community health centers, schools and adult education centers, beneficiaries' homes, and social service agencies. The least effective settings were those where health insurance for children would be the least relevant: fast food restaurants, libraries, senior centers, grocery stores, battered women's shelters, and laundromats. Direct mail, incentives for education/outreach staff, signs and posters, public transportation ads, and billboards were also rated as the least effective activities. Applicants who apply for Medicaid at places other than the welfare office are less likely to report stigma associated with the Medicaid application process.[86]

Findings from a 50-state survey on eligibility guidelines and enrollment procedures for children under SCHIP and Medicaid show that reducing verification requirements—or accepting a family's self-declaration of income and other information on the form—makes it more likely that a family will be able to complete the application process.[87] For example, streamlining the verification process in Michigan reduced incomplete Medicaid applications from three-fourths to fewer than 20%. New Jersey saw a 28.6% rise in enrollment for children, families with children and pregnant women after coverage was expanded for parents, and a new family coverage application implemented. Easing the application requirements for Medicaid and SCHIP by reducing the application to one page, limiting documentation to proof of identity, and issuing enrollment cards to eligible people the day of application resulted in an unprecedented increase of applications from 8,000 applications to 75,000 per month in New York City. The number of children enrolled in Texas's Medicaid program increased 30% over the previous year, and average monthly approval rates for applications rose from 57.5% to 70.1%, following implementation of Texas's Medicaid simplification law, which allowed parents to mail-in applications and renewal forms, allowed self-declaration of assets, streamlined documentation requirements, and offered 12 months of continuous eligibility.[88]

Despite the documented successes by states to increase enrollment of children into Medicaid and SCHIP, a new concern is that procedural barriers may be re-imposed as a means of reducing Medicaid spending in an era of national and state budget cuts. Several states stopped enrolling children into their separate SCHIP programs due to state budget concerns as early as 2001.[89] According to the Kaiser Commission on Medicaid and the Uninsured, 26 states reduced or restricted Medicaid eligibility for fiscal year 2003.[90] The Center on Budget and Policy Priorities estimates that proposed state Medicaid cuts in 22 states could eliminate Medicaid, SCHIP, or related public health insurance coverage for 1.7 million people.[91]

Recommended State Approaches to Improving Coverage for Latino Children and Families

Evidence-based research reviewed herein suggest that state approaches to decreasing barriers to health coverage of eligible latino children involve: 1) reducing financial barriers and access to healthcare coverage for parents to increase enrollment; 2) reducing nonfinancial barriers to enrollment; and 3) disseminating federal guidance on public charge, social security number requests, and LEP to protect the civil rights of all latinos. Table 3 provides a summary of major findings, barriers and proposed strategies.***

State Approaches to Reducing Financial Barriers to Health Coverage. As noted in Table 2, less than half of nonelderly latinos have employment-linked health benefits and, thus, a significant number of latino children and adolescents have no health insurance, although one or both of their parents may work. Policies designed to remedy the insurance gaps often focus on higher-wage workers, thereby neglecting low-wage latino workers. For low-wage latinos who often do not qualify for public health insurance benefits, health benefits linked to work sites may be more effective. Currently, only 60% of low-wage workers earning less than $7 per hour have access to job-based coverage, compared to 96% of higher-wage workers earning at least $15 per hour.[91-94] While employer-mandated policies may pose economic risks, such as potential job loss or dislocations, the public benefit gained supports public subsidies.[95] Expanding the eligibility requirements of Medicaid to include the working poor could reduce the rate of the uninsured for latinos by 37%.[96] States are supportive of reducing requirements for employer contributions, minimizing waiting periods without health insurance coverage, and easing requirements for health plans (such as benefits and cost-sharing limits) as a means of addressing barriers in coordinating with employer-sponsored insurance.[65]

To improve eligibility (public expansions and employer-based), states have several options to expand health insurance benefits to low-income (below 200% of FPL), uninsured adults (Table 3). A few states have designed mechanisms that extend benefits to low-income parents by using combinations of Medicaid Section 1115 waivers, Section 1931 of the Social Security Act, and SCHIP funding. Of the 15 states that have extended their coverage to low-income adults with children, only two—California and New York—have a high concentration of low-income latino families and children.[97] For example, to cover low-income adults with children and make new matching funds available for state-subsidized insurance programs, low-income parents could be permitted to buy into the Medicaid program at subsidized rates on a sliding fee-scale basis.[98] Broad Medicaid expansions to include coverage of low-income parents and their children can increase access to healthcare services, including preventive services, and help reduce unmet health and medical needs among latinos.[99]

State Approaches to Reducing Nonfinancial Barriers to Health Insurance Coverage. To expand our understanding of underenrollment of eligible children in SCHIP and Medicaid, we assessed state requirements for enrollment using 12 access indicators (see Table 2). Of the nine states, four do not have approved or pending applications for SCHIP Section 1115 Demonstration projects.[90] In two of these states (Florida and Texas), almost two out of every five latinos do not have health insurance. Six out of the nine states have a combo SCHIP program.**** Arizona and Colorado have developed separate SCHIP initiatives, and New Mexico opted for a Medicaid expansion. The eligibility level ranges from 185% of the poverty level in Colorado and Illinois to 350% of the poverty level in New Jersey. Not unexpectedly, these limits are likely to change or new enrollments limited due to pending state budget cuts. Notably, all states have a joint application$^{\Delta}$ under Medicaid and SCHIP eligibility (New Mexico's SCHIP program is an expansion of Medicaid). While seven states have eliminated the face-to-face interview under Medicaid for children (except New Mexico and New York), eight states have eliminated the face-to-face interview and asset tests for SCHIP eligibility. Two of these states have not yet eliminated asset tests for Medicaid for children (Colorado and Texas). Four states (Florida, New Jersey, New Mexico, and New York) have presumptive eligibility for Medicaid-eligible children but only two states—New Jersey and New York—have presumptive eligibility under separate SCHIP.[§] Four states are inconsistent in allowing 12-month continuous eligibility for both Medicaid for children and SCHIP. Only Florida allows self-declaration of income under both Medicaid and SCHIP. Disenrollment was reduced by 20% in Florida after the implementation of four policy changes, which included expanded eligibility criteria, reduc-

tion in the family share of the premium, expansion of the mental health benefit, and implementation of a 60-day wait period to re-enrollment in the program for children who involuntarily disenrolled due to nonpayment of premium.[80]

States are encouraged to build upon existing efforts to develop appropriate, targeted mechanisms to provide equitable access to eligible children, particularly latino children. Lower-than-expected enrollment of eligible latino children demonstrates the need for more targeted outreach efforts to increase enrollment.[91] The principal barriers identified include: the lack of parental awareness of eligibility and complexity of the application process. Many latino families who are eligible for Medicaid or SCHIP are not enrolled because they do not know where to go or how to apply.[92] A burdensome application process that requires verification of assets and income (often difficult for some families to provide) may discourage recipients from applying for insurance coverage.[56,59] Effective state strategies (Table 3) include: wider distribution of eligibility information at sites where eligible enrollees are, such as food stamp and WIC offices, Head Start, and local community centers; out-stationing eligibility workers to community-based sites and non-government offices; training community health educators to conduct outreach on eligibility and enrollment procedures for public health insurance programs; streamlining the application process using one form for Medicaid and SCHIP; providing bilingual staff and/or interpreter services; and providing a toll-free number for potential eligibles.[68,93,94] Data from the 2001 California Health Interview Survey supports the need for outreach strategies through worksite education and other means to more effectively target and enroll uninsured latino children in California where 78% appear to be eligible for public health insurance.[29]

State Approaches to Reducing Social Policy Barriers to Health Insurance Coverage. Immigrant parents are not seeking public health insurance benefits for which their children are eligible. New public charge guidelines clarify that persons eligible for Medicaid and SCHIP will not be penalized during future INS reviews for citizenship or permanent legal status.[71,100,101] Dissemination of these guidelines to providers and eligible recipients serves to increase access to healthcare services.[10] These policy guidelines were issued to ensure consistent application of Title VI of the 1964 Civil Rights Act to health and social services programs funded by HHS. The Department of Justice and the Department of Health and Human Services, Office for Civil Rights have reissued policy guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting Limited English Proficient (LEP) persons.[102,103] State or local agencies, private institutions or organizations, or any public or private individual that operates, provides or engages in health, medical, or social service programs and activities that receive or benefit from HHS assistance have the responsibility for ensuring that their policies and procedures do not have the effect of denying LEP persons equal access to federally assisted health, medical, or social service programs, benefits, and services for which such persons who qualify. Improving language access can also reduce medical errors and improve patient compliance. As documented by The Commonwealth Fund, Spanish-speaking Hispanics have more problems comprehending prescription bottle instructions, communicating with doctors, and understanding other written health information, compared with other groups.[104] Among Hispanics assisted by an interpreter (most likely a staff person, family, or friend), only 70% fully understood what the doctor was saying.

Several major barriers affect eligible immigrants' access to public health benefits. To increase access, we propose a set of strategies, including training and using community health educators to reach the entire community and to build trust, determine eligibility at clinics; and disseminating and enforcing federal guidelines for providing services to LEP (Table 3). In California, the outstationing of eligibility workers has proven to be an effective strategy, given that two-thirds of new Medi-Cal enrollees applied for the program through community sites.[105]

CONCLUSIONS

The U.S. Department of Health and Human Services has developed national goals and objectives on disease prevention and health promotion for the year 2010.[81] However, only two objectives directly address the financing of services related to children: immunization and infectious diseases, and clinical preventive services. Yet, eliminating financial barriers by developing and expanding publicly funded insurance programs is clearly not sufficient.[1,79,83]

Our data confirm a persistent trend of financial, nonfinancial, and social policy barriers that decrease access to healthcare services for Medicaid- and SCHIP-eligible latino children. State data

for latinos show significant variability that has implications for state responsiveness to promoting latino children's access to health insurance coverage. The proportion of latino children under the age of 18 has increased from 8.8% in 1980 to 17.1% in 2000. By 2020, it is projected that more than one in five children will be latino. Although Medicaid and SCHIP coverage rates are not readily available by state for latino children, the high rates of child poverty—especially in New York and Texas—and the high rates of uninsured poor children in Texas, Arizona, and California suggest that many eligible latino children are uninsured.[16,106,107] Health insurance coverage rates for latino children continue to be lower than for other groups for both employer-based and public health insurance.

Available resources for primary and preventive care do not meet the needs of eligible latino children who reside primarily in inner city, rural, and migrant areas.[48,108,109] The Congressional Hispanic Caucus (1991) testified before Congress that in El Paso, Texas, only 30 out of 800 physicians practice in the poorest part of the city, which houses 32% of the city's population.[110] Low-income areas have 44% fewer physicians than high-income areas.[110] Physician shortages in low-income areas lead to higher rates of emergency room use and increased morbidity among latino children.[110] Thus, a mismatch between the limited health services availability and concentration of needs may lead to decreased use that becomes misinterpreted as a product of low demand rather than an access issue.[50] Medical providers and staff in medical sites play a critical role in informing LEP families of eligibility for publicly funded health insurance programs and assisting them with program enrollment.[112] Furthermore, states with high concentrations of child poverty have less fiscal capacity to provide adequate services, and oftentimes less willingness to reallocate resources for child health programs. In both instances, the federal mechanism of state-matching funds does not decrease the variation in state spending on poor children.[46,113]

Latinos are most likely to be affected in an economic downturn, when employer-sponsored coverage declines and Medicaid can only absorb some of the loss in coverage.[96] For example, during the four months following the terrorist attacks of September 11, 2001, latino unemployment rates rose 23.4% compared to 17.2% for African Americans and 18.6% for NHW.[114] Continuous eligibility, regardless of changes in family income, is therefore important. As noted by The Commonwealth Fund, even brief gaps in coverage can contribute to problems in accessing care, obtaining prescriptions, and paying medical bills.[115] Medicaid expenditures also fall when people have coverage for longer periods.

Targeted state-level programs to increase enrollment in Medicaid and SCHIP are necessary to ensure the delivery of equitable and quality health services and to improve the health status of latino children. The high concentration of latinos in nine states argues compellingly for state-specific policy to address the healthcare access issues of eligible latino children in cooperation with the federal government. In addition, systematic monitoring and enforcement procedures must be applied to assure compliance with existing federal guidelines that protect the right of latinos to public health benefits.

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FOOTNOTES

* Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgement of the Secretary, (are) likely to assist in promoting the objectives of (the Medicaid statute). Flexibility under section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. States commit to a policy experiment that will be evaluated. A formal proposal for a research and demonstration project is prepared by the state and submitted to the Centers for Medicare and Medicaid Services (CMS) for discussion and review. Federal agencies, including CMS, identify issues and discuss them with the state in depth. After the state has responded, negotiations take place. CMS usually develops terms and conditions which outline the operation of the proposed 1115 waiver. The demonstration must be budget neutral over the life of the project (generally five years) and is subject to the Office of Management and Budget (OMB), CMS, and Departmental approval. The demonstrations cannot be expected to cost the federal government more than it would cost without the waiver.

** Public charge has been used in immigration law as a means of excluding individuals from admission to the U.S. and status as a

legal permanent resident for many years. The Immigration and Naturalization Service (INS) defines public charge as "an alien who has (for deportation purposes) or is likely to become (for admission or adjustment of status purposes) primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense."

*** Evaluative summary data on SCHIP are not readily available for several reasons. First, these programs are relatively new, and evaluation data are just becoming available. Second, states implemented more than one of the strategies at a time, making it difficult to examine the impact of any single strategy. Finally, SCHIP programs were not required by the federal government to collect racial or ethnic data until August 2001.[81] Consequently, few states have reported enrollment data by race or ethnicity. State data regarding the number and percent of children who are eligible for SCHIP or Medicaid are also not available by race and ethnicity.

**** SCHIP's authorizing legislation allowed states to extend coverage by establishing separate programs, expanding Medicaid coverage or a combination of both. This allowed states with existing children's health programs easy access to SCHIP funding. States that did not want to create an additional bureaucracy could expand access through Medicaid.

Δ A joint SCHIP/Medicaid application is particularly important for states that use their SCHIP funds to create separate child health programs. The simplest way to meet the "screen and enroll" requirement is to use a joint application form. A state would review the joint application and determine Medicaid or SCHIP eligibility consecutively, without requiring the family to submit additional information. Medicaid enrollment can be accomplished without referring the family to another office or completing another application.

§ The Balanced Budget Act of 1997 gave states the option of allowing certain healthcare providers and other community-based organizations to "presumptively" enroll children in Medicaid who appear to be eligible based on their family income and age. In addition to health professionals and staff of school-based health programs, the legislation allows WIC programs, Head Start programs, and state or local agencies that determine eligibility for subsidized child care and others to make Medicaid presumptive eligibility determinations. Presumptive eligibility helps families obtain health insurance for their children and can also help assure that children get needed medical care.

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